Medicare Part D Personal Information Worksheet

Use this worksheet to help gather all the information you need to choose a Medicare drug plan that meets your needs. Please fill out as much of the information on this worksheet as possible. You may find it helpful to gather all your prescription drug containers and your red, white, and blue Medicare card, as well as other health insurance cards you may have in order to complete the worksheet.

Name: _____ **Date of Birth:** _____-_____-_____

Address: _____ **County:** _____

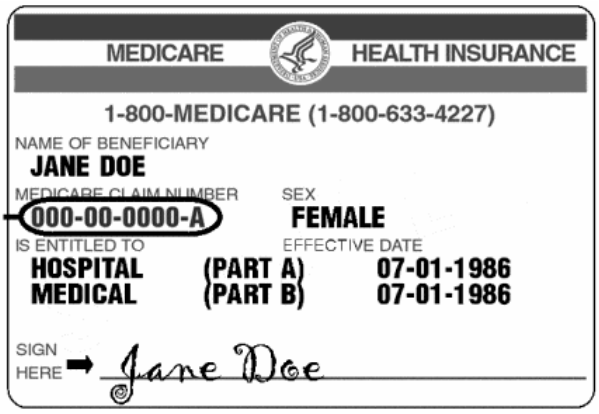
City: _____ **State:** _____ **Zip Code:** _____

Telephone Number: (_____) _____-_____

Medicare Number: _____-_____-_____-_____

Part A Effective Date: _____-_____-_____

Part B Effective Date: _____-_____-_____
(if applicable)


MEDICARE HEALTH INSURANCE
1-800-MEDICARE (1-800-633-4227)
NAME OF BENEFICIARY
JANE DOE
MEDICARE CLAIM NUMBER
000-00-0000-A
SEX
FEMALE
IS ENTITLED TO
EFFECTIVE DATE
HOSPITAL (PART A) 07-01-1986
MEDICAL (PART B) 07-01-1986
SIGN HERE
Jane Doe

Marital Status: Single Married* Widowed

** If you are married, your spouse will need to complete a separate worksheet.*

Are you a resident of a long-term care facility, such as a nursing home? ☐ Yes ☐ No

If yes, name of facility? _____

Address: _____ **Telephone Number:** (_____) _____-_____

City: _____ **State:** _____ **Zip Code:** _____

Name of facility's contracted pharmacy: _____

Is your monthly income <u>less than</u> $1,458 (single), or $1,966 (married couple) and your assets (not counting your home or car) <u>less than</u> $13,440 (single) or $26,860 (married couple) in 2014?

Individuals whose monthly income and assets meet the above guidelines may qualify for extra help paying the cost of their prescription drugs.

☐ Yes ☐ No ☐ I don't know

For SHIIP Volunteer Use: **Amount Saved $**_____

Volunteer Name: _____ **Date**:_____

Client Contact Completed: ☐ Online ☐ Paper **Follow Up Required:** ☐ Yes ☐ No

Your Current Drug Coverage/Medications

What type of drug coverage do you currently have?

- ☐ Medicare drug plan (Part D), which covers ***only*** prescription drugs and is not connected to any health insurance (name of plan, if known): _____
- ☐ Medicare Advantage plan (Part C), which covers ***both*** prescription drugs and hospital/doctor services (name of plan, if known): _____
- ☐ Prescription drug coverage through an employer or union health plan
- ☐ Prescription drug coverage through the United States military

List the prescription drugs you are currently taking *(please print; attach additional pages, if needed)***.**

This information can be found on your prescription containers. If you need assistance, ask your pharmacist. **If you have a current list of your prescriptions, you *do not* need to recopy them in the space below; simply include your list with this sheet.**

Drug Name	Dosage	Taken how often

List the name, phone number, city, and zip code (if known) of the pharmacies you prefer to use.

1. _____

2. _____

Please read and sign below

By signing below, I acknowledge that I am making my enrollment, or non-enrollment, decision freely and voluntarily. While I may receive information from a counselor with the Nebraska Senior Health Insurance Information Program (SHIIP), the final decision will be made of my own free will and choice. I understand that the counselor who assists me may be a volunteer and will only provide me with information to assist me in my decision. I further understand that drug pricing data available on the www.medicare.gov Plan Finder is only an estimate and subject to change. I hereby release any and all liability that may possibly be attributable to the volunteer counselor and agree not to pursue any legal action against the counselor and/or SHIIP for actions taken in their capacity as a volunteer counselor.

Signature: _____ Date: _____